

## INTERFACILITY TRANSPORT TASK FORCE

### MEETING

OCTOBER 25, 2005 LITTLETON, NH

#### Members present:

Dave Dubey, Berlin EMS/ EMS Coord. Board; Clay Odell, NHBEMS; Kim Thayer, Littleton Reg. Hosp.; Alisa Butler, DHHS-Rural Health; Jonathan Dubey, Berlin EMS, Will Riley, North Conway Ambulance Service, Jean McGovern, Littleton Regional Hospital, Kurt Lucas, Littleton Regional Hospital

#### Members excused:

Jeanne Erickson, Speare Memorial Hospital; Chandra Englebert, Weeks Medical Center

#### Members absent:

Robin Gagnon, Woodsville Ambulance; Scott Howe, Weeks Medical Center; Deanna Howard, DHMC, Nick Mercuri, LRGH/Trauma Medical Review Comm.; Adam Smith, Ross Ambulance; Michelle Willette, Stewarts Ambulance; David Santamaria, Stewarts Ambulance

- Dave Dubey related a story that a person contacted him by phone demanding to know why he was helping to create a law prohibiting all commercial ambulances from refusing transports. Dave set this gentleman straight, but the group discussed ways to counter the rumor-mill that generates and circulates disinformation. At the last meeting the group discussed getting information about the Task Force's work to a wider audience.

Clay continues to submit notes from the IFT Task Force meetings to be posted to the NHBEMS website. They can be viewed at the "Updates" section of the website. The URL is <http://www.state.nh.us/safety/ems/updates.html>

Clay also submitted a draft of a letter / email message to send out to all participants of the March 2005 Interfacility Transport Summit, and to other important parties as well. He will attach notes from the last few IFT Task Force meetings. The group made some suggestions, and Clay will incorporate those suggestions into the letter and submit a second draft to the group via email. He anticipates sending the packet out in early November.

- The major effort of today's Task Force meeting was to review actions taken on the IFT Task Force's work plans and to make revisions as necessary.
1. *Eliminate decision-making based on ability to pay. Pursue a process that is blinded to insurance information for ambulance service acceptance or refusal of a transfer request.*

At the September meeting a subcommittee was appointed to address a particular roadblock to the continued work toward this goal. The subcommittee has met with one party involved and is coordinating meetings with other parties. The subcommittee hopes to report back favorably at the next meeting.

2. *Draft a generic decision tree to match patient needs with ambulance resources. This will address issues of clinicians complicating the acquisition of an ambulance because they request levels of care that are higher than the patient really needs.*

The task force members again reviewed the draft documents that Weeks Medical Center had composed. Members of the Task Force had been requested to share the draft document with the appropriate parties back home and discuss their feedback. The feedback was positive, noting that each facility would have some changes to the generic version. The task force will continue work on this project and Clay will try to get additional documents from LRGH / Huggins and will re-distribute the “patient acuity levels” discussion in the draft of the NHTSA Interfacility Transport document. The plan is to come up with a “generic version” of a transport triage document to be presented at the followup summit meeting (see discussion bullet below). In the meantime some parties may be working on the document (Weeks for example) and may share at the summit meeting what changes they made and who was involved in that process. It was further discussed that the task force wants to present at the summit the following:

- Generic transport triage tool
- Recommendations about who should be involved in customizing the document at the local level
- Recommendations about how to educate hospital and EMS staff about the new tool (with technical help from the task force)

A discussion was held about the need to clarify the terms “Emergent / Urgent / Non-Urgent”. Previous discussions of this issue focused on matching the needs of the patient with the appropriate resource of the EMS agency, and this focus is still paramount. However it has been observed that some EMS agencies that have a full time crew on to cover 911 needs in their area, will use that on-duty crew to do “Emergent” interfacility transfers. This practice is somewhat problematic because it may not ensure coverage of the area for 911 service. If a hospital has an “Urgent or Non-urgent transport”, the practice is for the EMS agency to try to find a crew to do the transfer before committing to do the transfer. There is a perception that some hospital staff are aware of this and classify transfers as “Emergent” that are not really emergent, because they know the EMS service will send their on-duty crew immediately. This manipulation of the system must be addressed.

Further discussion about this topic included the need to apply the concept of QA/QI to this process. If hospitals have the triage tools but either the hospital or EMS agency does not comply with the tools, there must be a mechanism to address compliance. It is anticipated that most disagreements would be handled between the two entities themselves, but the group felt that there should be a third-party mediator/arbitrator to go to if issues are not resolved satisfactorily at the local level.

3. *Investigate the sharing of crew resources between services for episodes where a full crew is not available but an appropriate EMS provider from another service is ready and willing to serve as a crew member.*

At the last meeting the group felt that the method of crew sharing most likely to succeed is each service expanding their per-diem pool to include EMS providers from other services that will fill a need infrequently.

The group discussed what EMS services are required to do to bring on a new per diem employee. These tasks include: paperwork with the NH Bureau of EMS, contacting insurance carriers to put employee on insurance rolls and perhaps conduct a DMV check, complete federal payroll forms, verify the employee's physical fitness for the role, and conduct an orientation/training program.

It might be useful for EMS services contemplating this idea to consider the employee in a new category such as "auxiliary". This would help differentiate the role of part time or perdiem EMTs - who are expected to do a certain number of shifts in a particular time period – with the new position which is much more sporadic and might not have the same requirements of the regular perdiem staff.

Dave Dubey was appointed to draft an educational module for this new category of employee. That draft will be considered at the next meeting. The consensus of the group was that we should hold off on further discussions with other EMS agencies about crew sharing until we have that piece.

- Will Riley spoke about an idea that many members of the group thought had some merit. He said North Conway Ambulance each month faxed to Memorial Hospital the dates when they had paramedic coverage and when they didn't. This is a local version of a "clearinghouse" concept that was brought forward at the Summit, but was chosen as a topic to pursue at a later date. But it could work at the local level in the meantime.
- The task force members decided to continue with plans to conduct a followup summit meeting to present the outcomes and suggestions of the task force's work. The audience is intended to be the same stakeholders that were targeted for the March 2005 summit. The group felt that March 2006 would be the desired timeframe for the summit meeting.
- Next meeting: The next meeting is scheduled for **December 6, 2005 at 10:00** at Littleton Regional Hospital. The task force appreciates Littleton Regional Hospital's continuing support for this committee's meetings.